

coverage if the individual fails to cooperate with the issuer's efforts to verify coverage, the issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may be established through means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage.

(3) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the issuer must treat the individual as having furnished a certificate showing the dependent status if the individual attests to the dependency and the period of the status and the individual cooperates with the issuer's efforts to verify the dependent status.

(Approved by the Office of Management and Budget under control number 0938-0703.)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.126 Determination of an eligible individual.

(a) *General rule.* Each issuer offering health insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual as defined in § 148.103.

(b) *Specific requirements.* (1) The issuer must exercise reasonable diligence in making this determination.

(2) The issuer must promptly determine whether an applicant is an eligible individual.

(3) If an issuer determines that an individual is an eligible individual, the issuer must promptly issue a policy to that individual.

(c) *Insufficient information*—(1) *General rule.* If the information presented in or with an application is substantially insufficient for the issuer to make the determination described in paragraph (b)(2) of this section, the issuer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information.

(2) *Failure to provide a certification of creditable coverage.* If an entity fails to provide the certificate that is required under this part or part 146 of this subchapter to the applicant, the issuer is subject to the procedures set forth in § 148.124(d)(1) concerning an individual's right to demonstrate creditable coverage.

[62 FR 17000, Apr. 8, 1997]

EFFECTIVE DATE NOTE: At 62 FR 17000, Apr. 8, 1997, § 148.126 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 148.128 State flexibility in individual market reforms—alternative mechanisms.

(a) *Waiver of requirements.* The requirements of § 148.120, which set forth Federal requirements for guaranteed availability in the individual market, do not apply in a State that implements an acceptable alternative mechanism in accordance with the following criteria:

(1) The alternative mechanism meets the following conditions:

(i) Offers health insurance coverage to all eligible individuals.

(ii) Prohibits imposing preexisting condition exclusions and affiliation periods for coverage of an eligible individual.

(iii) Offers an eligible individual a choice of coverage that includes at least one policy form of coverage that is comparable to either one of the following: